# Foster Parents/Relative Caregivers Notice of Claim

DHS Oregon Department of Human Services

**Foster Parent/Relative Caregivers Information**

Name(s): _____ Provider number: _____

Address: _____ City: _____ State: _____ ZIP: _____

Home phone number: _____ Work phone number: _____

Name of child in DHS custody: _____ Case Number: _____

Date of birth: _____ Branch name: _____

Name of child's worker: _____ Phone number: _____

Name of certifier: _____ Phone number: _____

My home is certified by: ☐ DHS or ☐ Other*: _____

**If not certified by the Department of Human Services, attach a copy of the certificate.*

Exact date of loss: _____ Location of loss: _____

Describe in detail how the loss occurred. If there is not enough room, please attach a separate sheet.

Provide photos and two (2) estimates of repairs with your claim. Remember: your claim must be submitted to the Risk Management Division within **90 days** of loss (address below).

| List Items Damaged by the Child in DHS Custody | Cost When Purchased | Date of Purchase | Cost to Repair or Replace |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |

| List specific injury and how it was sustained | Treating physician/hospital | Cost of medical treatment |
|---|---|---|
| 1. | | |
| 2. | | |

Owner of property damaged and/or name of injured person, if not the foster parents/relative caregivers:

Street Address: _____ City: _____ State: _____ ZIP: _____

Phone Numbers: (_____) _____ Work: (_____) _____ Cell: (_____) _____

**READ BEFORE SIGNING:** The loss or damage I claim resulted from the acts of the child named above. In presenting this claim, I attest to the truth and accuracy of this statement, the facts I have presented, and the damages claimed.

✍ _____ _____

Signature of foster parent/relative caregiver, or person making this claim — Date

Written notice of claim must be submitted to the Department of Administrative Services, Risk Management Division, **within 90 days of the loss** (ORS 30.298).

**Fax:** (503) 373-7337

**Mail to:** Risk Management
PO Box 12009
Salem, OR. 97309-0009

THIS FORM IS AVAILABLE IN ALTERNATE FORMAT UPON REQUEST

# FILING A CLAIM

**When a foster child injures foster parents, residents, or their property:**

- The claim must be filed with Risk Management Division within 90 days of the event.
- Payments do not exceed actual cash value for property losses or >economic= losses for injury.
- Economic means medical bills, loss of wages, and other documented out-of-pocket expenses.
- If the damage or injury was accidental and unintentional, payments are limited to $5,000.00 per occurrence.
- Your own medical or disability insurance pays first for injury claims. We pay first for property claims.

**We request this information when you file any claim:**

- A brief but detailed account of what happened: Who, what, how, why and where?
- The foster child=s name and age.
- The name of the child=s caseworker with phone number.
- A daytime phone for you and your home address.

**Property Damage claims also include:**

- Photographs of damage, and either receipts or estimates for repair or receipts from the original purchase. *(Your photos and receipts can be returned if you request it when you submit them.)*
- If your receipts are lost, send a photocopy of the coverage page of the owner=s manual or warranty. Tell us when and where and at what cost the item was bought.
- If the damage is structural, provide one or more itemized estimates for repair. The estimates should include the repair person or company, a list of materials, and labor cost per hour. These itemized costs should be equal to the final price.
- Retain the original damaged item until we pay in case we need to inspect.

**Injury Claims should also include:**

- Copies of medical bills showing the name and address of the doctor who treated you.
- A signed medical records release form *(you can get the form from us)*.
- Prescription receipts and related expenses with your private insurer's statements showing what was and was not covered.
- A letter verifying your wage loss from your employer and the written excuse from your physician which prescribed that you stay off work.
- Name, address, phone number, and policy number of your private medical, accident, or disability insurance.

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